DOCUMENT RESUME

ED 036 640 VT 010 316

TITLE	MENTAL HEALTH MANPOWER AND THE PSYCHIATRIC TECHNICIAN.
INSTITUTION	CALIFORNIA SOCIETY OF PSYCHIATRIC TECHNICIANS, SACRAMENTO.; NATIONAL ASSOCIATION OF PSYCHIATRIC TECHNOLOGY, SACRAMENTO, CALIF.
PUB DATE	68
NOTE	43P.
AVAILABLE FROM	NATIONAL ASSOCIATION OF PSYCHIATRIC TECHNOLOGY, 1127 11TH STREET, SACRAMENTO, CALIFORNIA 95814 ($2.00)
EDRS PRICE	EDRS PRICE MF-$0.25 HC-$2.25
DESCRIPTORS	*CONFERENCE REPORTS, CURRICULUM DESIGN, LEGAL PROBLEMS, *MENTAL HEALTH, *PARAMEDICAL OCCUPATIONS, PROGRAMING, PSYCHIATRIC HOSPITALS
IDENTIFIERS	CALIFORNIA, *PSYCHIATRIC TECHNICIAN

ABSTRACT

DYNAMIC CHANGES ARE TAKING PLACE IN THE FIELD OF MENTAL HEALTH CARE WHICH HAVE A GREAT EFFECT ON THOSE PEOPLE WHO PROVIDE THE PRIMARY SERVICES OF PATIENT CARE, REHABILITATION, AND TRAINING. IN RECOGNITION OF THESE CHANGES, THE NATIONAL ASSOCIATION OF PSYCHIATRIC TECHNOLOGY SELECTED "MENTAL HEALTH MANPOWER AND THE PSYCHIATRIC TECHNICIAN" AS THE THEME FOR ITS ANNUAL CONVENTION IN 1967. THIS REPORT PRESENTS SIX ARTICLES WHICH REPRESENT A SELECTED DIGEST OF THE PROCEEDINGS FROM THE FRESNO CONVENTION. THESE ARE "MENTAL HEALTH: THE DYNAMICS OF REVOLUTION," "MENTAL HEALTH MANPOWER IN TRANSITION," A SYMPOSIUM ON FEDERAL AND STATE REGULATIONS OF NURSING SERVICES, "LEGAL ASPECTS OF UTILIZATION OF PSYCHIATRIC TECHNICIANS IN MENTAL HEALTH SERVICES," "PRIVATE PSYCHIATRIC HOSPITALS," AND "PROGRAMMING FOR THE FUTURE." A CURRICULUM REPORT IS APPENDED. (BC)

ED036640

Mental Health Manpower and the Psychiatric Technician

Published under the auspices of The California Society of Psychiatric Technicians and The National Association of Psychiatric Technology

Mental Health Manpower In Transition

Interpreting Federal and State Regulations

Mental Health Patterns In the Next Ten Years

VT010316

PRICE $2.00

NATIONAL ASSOCIATION OF PSYCHIATRIC TECHNOLOGY

CALIFORNIA SOCIETY OF PSYCHIATRIC TECHNICIANS

Non-profit organizations devoted to improved professionalism and recognition as a means toward better behavioral care treatment and training of the mentally and emotionally incapacitated.

OFFICERS
NATIONAL ASSOCIATION OF PSYCHIATRIC TECHNOLOGY

PRESIDENT
Zeryl Dryden (California)

PAST PRESIDENT
Franklin F. Fiedler (California)

FIRST VICE PRESIDENT
Ted Low (Colorado)

SECOND VICE PRESIDENT
Elsie Ferguson (Arkansas)

THIRD VICE PRESIDENT
Rose A. Douglas (Massachusetts)

SECRETARY-TREASURER
Bette A. Outlaw (California)

FIXED TRAINING STANDARDS THROUGHOUT THE NATION

EXPANDED ADVANCEMENT OPPORTUNITY

FEELING OF DIGNITY IN EMPLOYMENT

PRIDE IN CONTRIBUTION TOWARD MENTAL HEALTH

PROFESSIONAL GROWTH

OFFICERS
CALIFORNIA SOCIETY OF PSYCHIATRIC TECHNICIANS

PRESIDENT
Don Wise

PAST PRESIDENT
Earl C. Wilkerson

FIRST VICE PRESIDENT
Warren Malone

SECOND VICE PRESIDENT
William E. Outlaw

SECRETARY-TREASURER
Laretta Thomson

REGIONAL DIRECTORS
CALIFORNIA SOCIETY OF PSYCHIATRIC TECHNICIANS

William V. Kalinauskas
Wood H. Smith
Frances Belongy
H. D. Whitfield
Helen Johnson
Isaac J. Claybrooks
Delois Higinbotham
W. B. Hoxie
Virginia Ledford
George L. Waggoner
Ophelia Williams
Frank R. Favela
Roy M. Goucher
Frances Watts
John O. Calderon

ED036640

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

Contents

Page No.

PREFACE ii
William Grimm

MENTAL HEALTH IN CALIFORNIA: THE DYNAMICS OF REVOLUTION 1
Dr. James T. Shelton
"The changing character of our hospitals, complicated financing of the new programs in communities, and the place to be found there by the psychiatric technician."

MENTAL HEALTH MANPOWER IN TRANSITION 7
Dr. James A. Peal
"Innovations in the use of treatment personnel in community mental health programs."

SYMPOSIUM: 14
Interpreting federal and state regulations which affect staffing standards for nursing services in state and local facilities.
Howard Worley
Ralph Zeledon

LEGAL ASPECTS OF UTILIZATION OF PSYCHIATRIC TECHNICIANS IN MENTAL HEALTH SERVICES 21
Attorney Robert Thorn
"A review of the legal implications of transition from state to community and federal programs."

PRIVATE PSYCHIATRIC HOSPITALS 24
Arthur Jost
"Will new staffing approaches and modification of roles help to close the manpower gap?"

PROGRAMMING FOR THE FUTURE 29
Senator Nicholas Petris
"A probing insight into changing mental health patterns and requirements for the coming decade."

APPENDIX I: 36
All that glitters may not be gold.

APPENDIX II: 37
THE CURRICULUM REPORT
Anabele Miller

Preface

The entire field of mental hygiene across the nation is in a state of rapid change.

Many trends which here in the late 1960's are transforming the field of mental health care and treatment into a dynamic new enterprise will have a marked effect on the people who perform the primary functions and provide the primary services of patient care, rehabilitation and training.

It was in recognition of this era of change, this historic time of revolution, that the National Association of Psychiatric Technology selected the theme, "Mental Health Manpower and the Psychiatric Technician", as the keynote of its annual convention at Fresno, California, in October of 1967.

Since it is the psychiatric technician who is most intimately involved in the day-to-day response to patient needs, it is he who will be most directly affected by changes and modifications in the systems of mental health care which ultimately will evolve.

As a pivotal figure within the professional mental health treatment team, he will play a key role in the changing character of the large state hospital as the trend toward decentralization continues. He will occupy a critical role in the development and growth of community-based programs. He must play a central role in the redefinition of treatment functions and personnel. He must make his voice heard in the formulation of public funding patterns and other political decisions which will impact upon the future of these community-based programs.

Most important of all, the psychiatric technician (or his counterpart professional under other title) must continue to perform as a responsible leader in the shaping of visionary solutions to the very serious manpower problems now facing the mental health professions throughout America.

In California and in other progressive states today, there is every indication that these problems and issues and changes are but a beginning – that the mental health revolution will continue to accelerate for many more years yet to come.

In many ways, evidences of this great transition are today most pronounced in the dynamic state of California. But they are likely to be but previews of the same evolutionary processes which other states will encounter within the next few years.

For that reason, the California Society of Psychiatric Technicians and the National Association of Psychiatric Technology have joined in the publication of this selected digest of the transactions of our provocative Fresno convention of 1967 in the hope that others who yet must face the problems and opportunities of this great revolution might in some small measure benefit from the insights of some of California's front-line mental health authorities.

William Grimm
Executive Director

Mental Health in California: The Dynamics of Revolution

by Dr. James T. Shelton

Dr. Shelton obtained his A.B. from Pomona College and his M.D. from the University of Southern California, doing his psychiatric residency at Langley-Porter Neuro-Psychiatric Institute in San Francisco. Shelton was clinical instructor in psychiatry at the University of California, San Francisco Medical Center, and has been Superintendent and Medical Director at Porterville State Hospital, Porterville, California for the past 14 years.

His credentials include: Diplomat of the American Board of Psychiatry and Neurology; accreditation by the American Medical Association as a Mental Hospital Administrator; and fellow of the American Psychiatric Association and the American Association on Mental Deficiency.

Shelton received the Golden Rule Award of the California Council for Retarded Children in 1961.

I believe it's customary that when your group meets throughout the various areas in California that the state hospital closest to the meeting area convention site handles the program arrangements and welcomes the various delegates. Although we at Porterville are some miles from Fresno, we feel this is our bailiwick, so we are very pleased to have you meet here.

As I reviewed the program "Mental Health Manpower and the Psychiatric Technician" and noted the various speakers that you are going to be listening to over the next three days, I concluded that a great deal of thoughtful planning has certainly gone into the programs this year because the theme of your convention recognizes trends we see in mental hygiene which are coming at an increasingly rapid rate.

Change, of course, always creates anxiety, and when change comes too rapidly, then anxiety reaches such a height as to almost result in panic. Recognition is given, at least in the selection of your speakers, to one of the primary trends that is occurring in our field of mental hygiene ; that is, the trend to community mental health service, rather than this service being centered almost exclusively in the State Hospitals.

The second trend that is tacitly admitted by your program is that of the changing character of the hospitals. Of course this would obviously follow with increasing the mental-health programming in the community. It almost goes without saying that the hospital is going to have to change its character, its programs, perhaps even its function, in order to keep up with this move toward the community.

A third thing the program tacitly recognizes is the point financing of mental health programs. As short as twenty years ago in 1947, the primary financing of treatment services for the mentally ill and mentally retarded was by states. The states, for the most part, picked up almost 100% of the tab, and, because of its funding, maintained control of the programs it financed. Very little was being done in county, city, local communities, and extremely little was done by the federal government. But it is quite obvious that the trend is shifting toward financing by state, federal and "local"– "local" being counties and cities. We have seen a combined funding by federal, state and local agencies such as we have in welfare programs. Currently, our mental health programs are being funded by these three sources.

The fourth trend, which obviously must follow because of the first three trends, is that the worker in the field of mental health must change his role to keep pace with other changes in the field. No longer can he act and do and perform as he has acted and done and performed in the last twenty years.

In your program I want to commend you because I see you realistically evaluating the present and looking to the future rather than, as some organizations in this field, emphasizing the past – particularly the past nine and one-half months. This period has been, as we all know, one of turmoil, recriminations, and what I think is most unfortunate, a a great deal of misinformation. I think the most disturbing factor has been the misinformation about the cutbacks, and the impact that this has had upon our treatment programs.

We have been hollering about the cutbacks during the last nine and a half months, yet it was after the first six months of the year before any cutbacks occurred. And, we heard very little emphasis being placed upon the freeze, which really had the greatest impact on our treatment programs. Although I tried, I couldn't convince anybody that the freeze was the thing to focus on – to get that lifted. We could probably take the cutbacks in stride, as we are doing.

The other piece of misinformation that I think has been the worst thing – I again read an organization's statement (it wasn't this one) about how horrible the conditions were at Stockton. I looked at this, read it over, and I said, "This cannot be the result of anything that has happened since the last nine and a half months, because nothing was involved during the last nine and a half months to affect the amount of money to feed patients. That has always been adequate. In fact, the department has always turned back money for feeding. While we've never had any lack of money to feed patients or to buy food, this was played up in a maudlin way to make people believe that this had something to do with the present administration. I think this is wrong.

I'm not denying that there might be a problem in this area. But the point I want to make is that we've had problems ever since we've had a Department of Mental Hygiene. We should be very careful about ascribing the causes of those problems to the present administration. It may not all be. Some may be, but not all. And I think it is very important to very carefully delineate that which is our own responsibility and in our own bailiwick to correct – within our own resources – rather than sitting back and blaming it all on something or somebody, or lack of money, or lack of personnel.

You see the same kind of thing in psychiatry with the parents who come to you with disturbed kids. The kids have all kinds of behavior problems, but normal kids have behavior problems too. Before you can honestly and factually determine what really is abnormal, you have got to know what the normal problems are so you will not be confused and say it's all due to a particular condition. I think there is a good analogy here. We've got to sift out what our normal problems are, and not blame them all upon the present situation.

Sometimes, I think the time we spend on complaints, petitions and other movements might be much better spent on more constructive endeavors and on patient care. Now, we are living with the present situation, and it hasn't been something that any of us has liked. We've all lost something – the hospitals for the mentally ill much more than the hospitals for the mentally retarded. There is no question about that, but we are living with it. There were lots of dire predictions about the cutbacks. For example, I sincerely thought that the population for the mentally ill would increase because of the decrease in personnel. But the facts do not bear this out. The facts are that the population is still continuing to decrease. We cannot ignore these facts – they're the facts of life. I don't think myself or anyone in the De-

partment or the Administration likes to hold the line based upon a level of care which is not adequate and which has lots of holes in it, particularly in terms of not considering admission factors adequately. Yet, we put up a battle and fought it. Instead of sitting back, sulking and crying in our beards, we should endeavor to move ahead with what we have. I, for one, hope – and I think we have many indications for this hope – that we will go ahead next year even though this year has been one of holding the line and, in some cases, of actually retrenching.

I wrote a letter for our Porterville State Hospital Parent Group and our employees to cover just some of the things I am mentioning, and I was extremely surprised to receive a letter from our Governor who apparently had seen a copy. I had said, in essence, "Let's quit bickering and complaining and do with what we've got to the best of our ability." The Governor wrote that this attitude was sincerely appreciated by him. He said, "It certainly was good to read the voice of reason in all the sound and fury, and I hope others will follow your example." The letter was signed, "Sincerely, Ronald Reagan." Now, Ronald Reagan is our Chief Executive; he is our Governor. And as I tell new employees at the hospitals, "Even though we, as civil servants, owe a certain amount of respect to him as Chief Executive, we don't have to agree with him, but we don't have to knock him. He is doing what he thinks has to be done at this point in time. We may disagree, but he's made the decision. If someone disagrees so strongly that he can't accept it without being negative and vicious at times, then I think it is his responsibility to get out of the system. I'm not saying that you should do this before you fight for what you believe in. But once the decision is made, you should accept it and look to the future doing what you can with what you have rather than crying over spilled milk.

You know, we've come an awful long way in the Department of Mental Hygiene since 1947, twenty years ago. Here it is 1967. I mentioned 1947 because this was the time of Governor Warren, Frank Tallman – the time when headlines were filled with references to the "snakepit."

The interesting thing, though, is the difference in programming in 1947 from that in 1967. Now we have thousands of additional new employees. Salaries have skyrocketed – still not high enough in my opinion – but certainly an improvement over 1947. Then, a psychiatric technician got $40 a month plus live-in, had a set of keys thrown at him, and he went to work with the mentally ill and mentally retarded without any training. We've come an awful long way since then, so I think that rather than crying in our beards we ought to just reflect on how far we have come and try to work with what we have. Despite the freeze and cutbacks with which we do not agree, we have something this year that we have never had before in mental hygiene – greater flexibility in the use of staffing budget. Most of you don't have too many dealings directly with the operating budgets of the hospitals, but I can tell you as hospital superintendent of many years, I have never seen the flexibility that we have this year in spending dollars for treatment personnel.

While this flexibility is limited to the classifications of physicians, social workers, psychologists and psychiatric technicians, it is a marked improvement over the time when such did not exist. We can convert vacant positions to other positions that we are able to fill on a dollar for dollar basis. At Porterville we've had physician positions and psychologist positions vacant for nearly two years. We are taking money for these positions and plan to create some 30 new psychiatric technician positions this fiscal year. We are giving first choice to trained psychiatric technicians from the hospitals for the mentally ill who may be faced with lay-off. These are psychiatric technicians who are already fully accredited so we don't have to put them through an in-

tensive training program other than an orientation to the hospital. Our patients therefore, benefit from this flexibility in the utilization of staff funds because we are permitted to use dollars which normally would not be available to us. I think this flexibility is something on the positive side of the ledger of which people need to be made aware.

One other thing I think a lot of people are not aware of is the fact that the Governor ordered all of his State Departments in California to reduce this years' budget by eight per cent – *EXCEPT* the Department of Mental Hygiene. While I'm not rolling in the aisles with pleasure over features of the present programs, these desirable things should be recognized along with the less encouraging factors.

I have read the Governor's letter to the Director of Mental Hygiene concerning budget proposals for the next year. Economy is mentioned, but there is also instruction to give full consideration to new programs and to augmentation of current programs if they are found justifiable. We have submitted some six programs from Porterville for budget augmentation in the amount of some three or four million dollars of additional funds. We're not going to get that much, but if we get five hundred thousand, that's better than nothing. I might add that most of those budget augmentations except those for research, call for additional personnel – additional psychiatric technicians.

So where are we going, and what is going to be the role of the psychiatric technician? Well, you're going to hear speakers who will give you some of their ideas of where they think the psychiatric technician is going and perhaps what the role of the psychiatric technician will be. You will undoubtedly receive a great deal of information about the movement to the local community mental health programs, one of which is the Lanterman-Petris-Short Act, Senate Bill 677, which is known also as the "California Mental Health Act of 1967." This will profoundly affect the hospitals for the mentally ill, but will have less affect on hospitals for the mentally retarded and Atascadero since patients in these facilities were excluded from the bill.

You are undoubtedly going to hear about the impact of the Federal Government, Medicare and Medic Aid. You're going to hear about the Department's emphasis on cost reporting. You've already been involved with that in some of your ward surveys. All of this is done in an effort to get more federal dollars. This is the whole purpose of some of the discussions that are going on about Medicare and Medi-Cal.

In an effort to get more dollars so that more services can be provided, and this is the avowed intent of these programs, we're going to have to contend with problems of federal law which set forth certain definitions for certain kinds of people that are necessary. We're wrestling with this. I think it was important that the Fairview situation with the conversions of psychiatric technician to registered nurses was subsequently called to a halt, and then looked at very thoroughly, because there may be other compromises or other approaches. It is not impossible to change federal regulations by broadening their definition. These are the things that should be looked into, I think, by a group such as yours. There seems to be no reason at all why federal regulations involving Medi-Cal and Medic-Aid, which is a federal program for the states, could not be written so that where mentally ill and mentally retarded are involved, the psychiatric technician could be on the same plane, if you will, with the registered nurse. After all, administrative regulations can be and should be changed periodically to meet our needs.

I think we're going to see a decrease in the number of 24-hour hospital care programs. We've seen that in today's Short-Doyle programs. I think, of course, that this is best proven by the decrease in the populations in hospitals for the mentally ill, except that we're seeing a change in the population to the more

profoundly sick, whether they be the "back-wards patients" or the severely retarded, or the geriatrics cases. We're more and more going to have to care for that kind of case in the state hospitals as the communities begin to provide care for the easier-to-care-for patients.

This means that the role of the technicians and the personnel in the hospitals will gradually change. You're going to have to become more skillful. We are talking now in the Department about considering multi-purpose facilities, so that state hospitals could care for both the mentally ill and the mentally retarded and all kinds of mental disorders. You already see the movement toward this with DeWitt State Hospital. They have more retarded there now than mentally ill, and of course there is the mentally retarded unit at Patton, the unit at Agnews, and now the unit starting at Camarillo. Then, the plan (I think it is being done at the present time) is to transfer some mentally disordered sex offenders from Atascadero to Napa. That's probably just the start of hospitals becoming multi-purpose facilities in caring for all kinds of problems. This is going to change the role of the hospital and the role of the worker in the hospital. Undoubtedly the hospital will become a back-up service to the community. Hopefully the hospital will become, and I think it a proper role, a training center where people can come in and really learn how to care for the mentally disordered. The people who really know how to care for them, we have found, are in the hospitals. I happen to be active in community mental health programs through service on the Tulare County Mental Health Advisory Board for the Short-Doyle program. It's astonishing sometimes how the professional workers in the community are unaware of the difficult problems which are second nature to us in the hospitals. So we have a double role to play here in the training of the professional who does the work in the community. There's a psychiatric technician who has done a marvelous job at Tulare County Hospital in the psychiatric unit. He's had some experience in state mental hospital work. I was talking to him and he said he thought this was the most valuable part of his experience and training. Here is a psychiatric technician who is working in the community in one of these Short-Doyle programs and there are many others besides him, of course. There is a growing use of the psychiatric technician. I include the psychiatric technician as a "professional" even though he is sometimes referred to by some as a "sub-professional". I still like to conceptualize the psychiatric technician as a professional with talents equal to the registered nurse.

This doesn't mean that they don't have separate functions to perform. In my opinion, the registered nurse has much more experience and training and knowledge concerning the medically ill patient, such as an expanding hydrocephalic. This isn't to say that the psychiatric technician can't learn these elements, and is beginning to do so. On the other hand, I see no reason to use a registered nurse on a ward which is better run by a psychiatric technician out on the campus where you are dealing more with educational - habilitational problems. We use them on our co-ed ward.

I do think that there may be a trend in the future toward some kind of an amalgamation of these fields – registered nursing, if you want to call it that, and psychiatric technology. Perhaps the combination would have some other name which is yet to be devised.

I think, however, we make a mistake in spending time fighting between ourselves on this rather than trying to pull together and recognizing that we both have a job to perform. If you don't feel that your particular hospital has an appreciation of the need for both groups, then I think that CSPT has a role to play in convincing the hospital administrations, and anybody else concerned, that there is every need for both kinds of professional workers in the hospital.

I hope this morning that I have given

you, besides a cordial welcome, somewhat of an overview of the situation as I see it. I think I have been able to reasonably well keep within my time. According to my watch, it's two minutes after ten, and that's just about the time that your program calls for coffee. Thank you very much.

PLEDGE OF THE
PSYCHIATRIC TECHNICIAN

Having developed an awareness of the dignity encompassed in the field of psychiatric technology and of my responsibility because of specialized training in the therapeutic techniques utilized in the promotion of mental health,

I pledge myself:

To uphold the integrity and human dignity of those entrusted in my care and protect them against humiliation, insult or injury without regard to race, color or creed.

To inspire hope and confidence, giving assistance with understanding and friendliness, in finding realistic and meaningful living.

To continue my development of professional competence, complementing scientific study, improvement of therapeutic techniques and maintaining high standards of leadership in the field of Psychiatric Technology.

Mental Health Manpower In Transition

by Dr. James A. Peal

Dr. Peal is Director of the Fresno County Department of Mental Health Services. Well known as a pioneer in psychiatric services and in local programs, Dr. Peal has practiced in many California hospitals including Napa and Agnews State Hospitals as staff psychiatrist, the Medical Facility at Vacaville as Chief of Psychiatric Services, and Stockton State Hospital as Associate Superintendent. He recently returned from Michigan, where, as Assistant Director of the Department of Mental Health, he organized a manpower utilization and development program for that state. Licensed in Maryland, Connecticut, Michigan and California, Peal is also a Fellow of the American Psychiatric Association.

On December 31, 1965, there were 28,400 patients in the hospitals for the mentally ill and 12,920 patients in the hospitals for the mentally retarded. December 31, 1966, there were 24,057 patients in the hospitals for the mentally ill and 13,340 patients in the hospitals for the mentally retarded. These patients had already been extruded from their community through the existing commitment practices. They have been hospitalized, institutionalized and many have seen their fellow members returned to the community; some for a better life, some for a worse life, and some for an existence similar to what they had before they came to the hospital. I wonder if these patients think. "Am I included in the community program or is this for those who are yet to come here? Am I a part of the number that is to be written off?" The experience of being excluded is not new for the patient who has been in the state hospital on the back ward for twenty years because he has seen new programs come and go. He has seen patients selected for the new programs whose prognosis and expectation has been that he would recover. He has always just missed being picked for this or that. He has seen his fellow patient come, get treated, and go in fairly large numbers, for the Department of Mental Hygiene over the past few years has accomplished a reduction of over 10,000 patients through the advent of Medi-Cal and newer techniques in psychiatric treatment. It is to the patient who now sits on the back ward and those yet to come whose illnesses may not respond to the treatment now possible in the community, it is to these people that we dedicate ourselves in this consideration of mental health manpower and the psychiatric technician .

Any comprehensive mental health program, whether local as in the present Short-Doyle programs or state as in the state hospitals, must include in all of its ingredients treatment programs designed to meet needs of all patients – not a selected few. If it does not do this, then it is a mental health program that is directed toward part of the community and not all of it. People who develop mental illness should retain their membership in the local home community regardless of any temporary sojourn to a state hospital or other treatment facility, and that community should accept this person back, offering him what rehabilitation services he needs and, more important, offering him a warm and friendly welcome home.

This organization and this institute is thus dedicated to the patients that we serve. Manpower is the means of providing the hope, happiness, and health to patients by bringing appropriate psychiatric skills to him in an atmosphere of

care. acceptance and understanding. Mental health manpower development and utilization, including staffing, training and funding, must be centered in meeting the needs of the patients we serve.

Today morale may be at its lowest ebb. This is the first time in many years the mental health budget has been cut instead of increased. The very existence of the system that trained and nurtured us is in question. We may find ourselves embittered and angry, bewildered and perplexed, hopeless and despairing.

You have seen your numbers shrink, your training programs reduced and all but eliminated, and demands placed upon you increased by your shortage in numbers. Your very worth to the system which nurtured you is being questioned. By virtue of the cut back, the institution you worked in, namely, the state hospital has been declared a thing of the past by some, to be replaced by the new community mental health Short-Doyle programs.

If you don't quite understand what these things are, it may be because they aren't very often clearly defined. Naturally you wonder where you fit in this new scheme of things, or if you fit at all. Does your profession have anything to offer now to the patients in community programs in this new order of things? I come to you today out of the experience closely identified with the state hospital. For I, too, received my psychiatric training in a state hospital and worked in various state hospitals, both on the wards and in the administration. I have participated in the third psychiatric revolution in which the newer modality of psychiatric treatment, namely, somatic treatment, drugs, group therapy and the therapeutic community system of patient management have changed our hospitals from custodial facilities into psychiatric treatment centers.

I now find as director of a community program that there is a greater need and challenge here at the community level to translate these programs into hope and help for those patients at the end of the line because communities have not been accustomed to accepting and keeping their sick people. They traditionally have sent them on to state hospitals. It is, therefore, my purpose today to first define what community mental health services mean to the patients, and then to examine with you some of these new community health centers, local programs, and Short-Doyle programs, and the new vocabulary they are bringing onto the scene.

Second, I will spell out the ingredients of these new community programs in terms that are familiar to you and that are similar to state hospital operation. I want to examine your present skills as they now exist to see how they fit into this program. Then we will examine the different ingredients in the local programs where your technology and skill as it now exists may not fit, and identify needed appropriate changes (additions and deletions) in your training to make your skills useful. We need to define some of the more immediate problems in courses of action that your organization must consider if it is to become a part of the community program, and finally to review the current political and legislative happenings to see what they hold for the present and for the future.

Community health services are those mental health services which exist in the community. The community is defined as a political subdivision or geographical subdivision which has a local governing board. The mental health services in the community are usually considered as direct treatment services, or those services given to patients, and indirect services which include consultation services given to helping agencies in the community.

For example, the local or county welfare department provides social services including room, board and clothing for all people who are indigent in the community. Consultation services to the welfare department enabling welfare workers to provide these services for the mentally handicapped is a very profitable

thing for the patients. It gets for your patient an adequate place to live, clothes to wear and food to eat, and provides other social services that keep him in the community. If the Welfare Department or its staff gets too nervous about him, these resources in the community may dry up; and he becomes a person without a home and, therefore, hospitalization is sought to solve his problem. The welfare worker can become a friend to the patient, a helper in the program.

By the same token consultation services to the Public Health Department can provide visiting nursing services. Visiting nurses and public health nurses are a major resource in keeping sick people at home. They help the patient with problems in medication; they give the patient a friend, someone who understands them, and someone who knows the neighborhood and is able to help the patient make maximum use of the resources there.

Consultation with law enforcement is a very useful program for it serves the same purpose as consultations with Welfare. The more the police and law enforcement officers understand about the problems of the mentally ill, the more skills they have in being able to manage them as policemen. Thus the patient has a better chance of having law enforcement available to assist him rather than having law enforcement designed only to incarcerate him. In general, by having a network of consultation and education services to these various helping agencies in the community, both public and private, one is able to enlist many services for patients that he otherwise would not get. The manpower involved in carrying out these consultations programs usually comes from professional people, i.e., psychiatrists, social workers, and psychologists. However, the psychiatric technician with his understanding of the nature of mental illness, his knowledge of sick people and how to get along with them may be a very helpful person in this overall consultation program. An additional advantage for the psychiatric technician is his membership in the community. As a lay member of the community he probably has more acceptance by the grass roots of these agencies than do the professionals. Just imagine, if a psychiatric technician were a member of the reserve police force, how much effective education he could give to his fellow policemen. This may be as effective as a lecture that the psychiatrist would give on the nature of schizophrenia or how you manage a person who is about to kill himself. However, these duties in community programs are not usually, at the present time, assigned to psychiatric technicians. The direct services program provides direct treatment to patients. It includes inpatient, day care and outpatient services.

Most local programs have a small inpatient service, (small compared to the size of the state hospitals) with from 5 to 90 beds servicing a county of 100,000 to over a million people. It is obvious that with this small number of beds that long-term inpatient hospitalization is not an integral part of the local program. An effective program treats acute disturbances in a few days. Patients who otherwise would require 90 or 120 days in a state hospital are more efficiently treated in a community program by using not only the inpatient service but the day care service and outpatient services all combined and coordinated in a treatment design to meet the patient's needs.

The practice of psychiatry in the community program presents many challenges and many stressful moments to the institutional trained psychiatrist and other professionals. Most community programs have a walk-in clinic. This is a place where anyone who is disturbed can come himself or be brought and be seen by members of the professional staff. One physician has termed this "instant psychiatry". That is, the patient is seen, and in 15 or 20 minutes a diagnostic evaluation is made and a treatment program is developed which has to solve the immediate problem of

where this patient has to live in order to be effectively treated. Generally if the manifestations of the illness do not make the patient a danger to himself or others, even though he may be quite disturbed, he will be given adequate dosages of tranquilizing drugs immediately and assigned to the day hospital or to the outpatient clinic and not be hospitalized.

It might be well to follow a disturbed patient through the various elements of this program so that you see how they work. A patient is found by the police having turned on the gas and closed off the windows in a bona fide suicide attempt. The patient is brought to the hospital on an emergency 72-hour commitment. The patient is examined either the same day or the following day by the chief of the inpatient service who is a psychiatrist, and a diagnosis and treatment plan is made that day. The treatment plan is started that day on the inpatient service. By the time the 72-hour commitment is up the patient may not be ready to leave the hospital so he is encouraged to sign a voluntary admission. He stays on the inpatient service until the acute manifestation of the depression has subsided and then because the patient is not ready to resume his full life at home he may be placed in the partial hospitalization or day care program.

The day care program consists of a series of highly organized, scheduled activities including occupational therapy, recreational, and group therapy that take up the patient's day. It is identical to the same daily program the patient has while an inpatient. The only difference is that the patient sleeps at home and not in the hospital. The patient is given his meals, medication and rehabilitation program in day care. When the illness has subsided and the patient begins to think of what he or she does next, he will be referred to vocational rehabilitation or returned to his home, school or job, as discussed all during the patient's hospitalization. The patient's plans for discharge are made almost immediately after coming to the program. After the experience in day care when the patient has more confidence in himself, he may be referred to vocational rehabilitation and/or may be sent back to his job in the community. The average length of stay on the inpatient service is 6 days for most illnesses. However, the average length of stay in day care may be 2 to 3 months, depending upon the degree of the illness. The patient may be discharged from day care and not come back at all or he may go from day care to outpatient situation for either drugs, group therapy, or individual therapy. In any case he is a free agent usually back working on his own.

Now you may say, "What about the patient who is chronically ill and who has had three and four episodes of illness?" These patients are provided for in essentially the same way. The acute manifestations of the disturbance are managed on an inpatient basis until the patient is able to manage himself at home. He then may be treated in day care which is the same treatment being continued but he is now able to live at home instead of the hospital, and he may be followed on an outpatient basis. We recognize that for this group of patients, identity with our center may be a lifetime one because their illness will come and go as they meet various stresses within the community. So we have to plan for these patients a long-term program of treatment with the goal of helping them to maintain as high a level of functioning as possible. The most meaningful goal though that one has to have for these patients is to enable them to live happily in the community and enjoy their lives.

Toward this end many volunteer organizations in the community help the patient to have fun. As an example, I cite the Senior Citizens. However, not all of the patient's life in the community is happiness and joy. Many patients find just as much desolation and loneliness in the third rate hotel rooms and in the flop houses or the nondescript boarding homes as they would on the wards of the

state hospital. In fact, you have had the experience of having patients refuse to leave the hospital. They have found more meaningful relationship in the state hospital community and, therefore, a more meaningful life. You have given them more acceptance and understanding there than they could find in the cold unfriendly community. What they need at home in their community is a familiar face, people who understand what they are experiencing, people who understand what being ill is like, who care and are there to help them through their experience. Psychiatric technicians are these kind of people and have done this kind of service in the hospital, and, in some places, are now doing it in the community.

Social welfare workers, physicians, and psychiatrists are also these kinds of people, but are not as involved in the stresses and strain of the daily living as the public health nurse, the mental health nurse and the psychiatric technician.

I would like to describe the functions of the inpatient, outpatient and day care programs and the required duties.

The inpatient service is similar to the admission and acute treatment wards in the state hospital. The main job is intensive psychiatric treatment. The nursing care is provided by psychiatric nurses assisted by licensed vocational nurses and attendants, and psychiatric technicians in a few cases. The present basic training of the psychiatric technician along with the Range B training would be adequate for this program. The following differences are important.

1. The hospital stay is short.
2. The patient is a free agent and is regarded as such.
3. The major emphasis is on rapid effective treatment and early return home.

Outpatient service includes home visiting and emergency care.

These services are new to the psychiatric technician except in some few places. The technician's knowledge and ward experience with the acute and chronically ill is a good background. The management of patients in these services is different. Home visiting is new to psychiatry. The technician is expected to be able to do things for patients by doing things with the patients. The goal of care here is to enable the patient to use the community and its resources as a full fledged citizen. Mentally ill people have not been so regarded or treated by the public or by the professionals caring for them. This requires the technician and all professionals to examine his own basic convictions. Are these poor mentally ill people as good as I am? Do they have the right to be my neighbor?

Emergency service is just what it says: care for people in crisis. The crisis may be determined by the patient or his caretaker. It usually comes when patients succeed in getting others nervous about them.

Day care programs are familiar to state hospitals and those technicians who have had this unique experience in state hospitals. Those technicians who have been part of the special Hospital Improvement Program project involving rehabilitation would be at home in the community programs, for many of the Hospital Improvement Program grants have prepared the people in them for the kind of practice that is carried out in the community: The Mendocino Programs – The Stockton State Hospital Program – The Camarillo Program – The Group Leader Program – Range B.

Local programs are authorized to be reimbursed for halfway houses and other appropriate protected living programs.

What can psychiatric technology do to meet the challenges of community programs? What are some of the problems it should consider?

1. Psychiatric technology can remain as it began and is now, an ancillary nursing service, providing basically nursing care. Whether he is an assistant nurse or a junior nurse is not important. The technology now is defined within the context of nursing and as such will be

viewed as a branch or sub-branch.

2. Psychiatric technology can take a hard look at what community programs are and what they will need, and add to its skills those which would make it provide some unique service in the program not now provided. These skills are in social service areas: knowledge of community agencies, occupational therapy, skills in use of crafts, public health aid, vocational rehabilitation. The psychiatric technician then becomes a generalist in community care, able to bring more skills to the patients. The degree of training in these areas would be less than that of the professional at the college level. Outpatients may not need these services from that professional.

3. These are some problems:

1. The psychiatric technician profession is basically state hospital nursing care-oriented as to training and salary.

2. Inpatient services in community programs are in county or private hospitals provided under service contracts. These county and/or private hospitals have never used psychiatric technicians.

3. There is no such position in county civil service structure.

4. Local mental health directors look at cost of manpower related to skills produced. Six thousand dollars a year buys a technician, nurse or mental health rehabilitation worker with A.B. degree. Who is more effective in doing the job? Program directors may not be aware of skills technicians have.

5. Opportunity for vertical promotion in community programs is limited. Technician supervisors, A.S.N.S. etc., are not used as such because there are not the large living units as in state hospitals. Supervisory positions in nursing are filled by psychiatric nurses, with or without degrees. Horizontal promotions based on responsibility for management of a program is more likely. There is not much of an established formal personnel organization in county government specifically for mental health programs.

6. Problems related to legislation: Community programs are funded by reimbursement. The service must be created and produced before it can be collected for. There is no advance capital to start new programs except from county funds. For example, Fresno County has approximately 600 former Stockton State Hospital patients here. We have designed and planned a program of continued care for them. In order to carry this program out we need to hire some people. There is a statutory provision for 100% reimbursement. The people would have to be hired out of this budget, the services rendered and then collected for. If there are no funds to hire them, the services are not rendered, therefore, cannot be collected for. It's the same problem faced by a broke mechanic who wants to start a garage or a broke cook who wants to open a restaurant.

7. Senate Bill 677* in its present form presents some problems. It provides for a more expensive system of care locally than counties presently have. The financing is by reimbursement with no capital for expanding or starting program. It eliminates the present commitment system before the alternative program can be developed. It also identifies mentally ill people in state hospitals as dangerous. This sanctions, by law, the fears and apprehensions the public has had about the mentally ill. The only mentally ill who can be involuntarily committed are those who have been certified as dangerous or those who are so disabled they need conservators. All others can go voluntarily to the state hospital; but who would voluntarily go to a place that has been explicitly designated for dangerous people? Would this be a safe place for treatment? The state hospital remains a major resource in mental health programs. The Department of Mental Hygiene is committed to providing an excellent level of care there and is integrating the two programs. Community programs cannot carry the treatment load alone. This language of the law compromises the effective integration of state hospital and community program by declaring the state hospital as the place for

dangerous people involuntarily committed and then encouraging all others voluntarily to go there. State hospitals have increased their voluntary admission rates, opened their wards, developed therapeutic community programs, and in some cases integrated their programs with the community. At the same time they have treated people who had dangerous behavior because of mental illness at no great risk to the safety of either community. This has been possible because the focus was not on the patient's dangerous and possibly permanent behavior, but rather on the patient's treatable and therefore temporary illness.

The SB677 implies that once mentally ill and dangerous always mentally ill and dangerous, and this is perplexing to both the patient and the staff and makes for suspicion and distrust of each other.

"I'm voluntary and safe."

"He's involuntary and dangerous."

"So if you're so safe why didn't they keep you in your local program? Why did you volunteer to come here?"

Likewise in the local program the same questions arise among the "three-dayer", the "fourteen-dayer", and the volunteers. Voluntary commitment which should arise from self-awareness and self-seeking of help may well become submission to the tyranny of the system which grows from fear. "If you don't go voluntarily for the treatment I think you should have, I'll have you declared dangerous and put away until you are proven safe."

In summary:

1. We must dedicate our thinking today to the patients of the state hospital community who are left behind, as well as to those in the non-hospital community who are here with us.
2. The discussion of the community program is our message to them that they still belong to the community of mankind and, therefore, retain membership in their own. They are in our thoughts, our plans, our hopes, and our ambitions.
3. The psychiatric technician remains a major resource in mental health. There are some challenges. The profession has to meet these challenges to remain a viable resource in the community program.
4. There are some immediate organizational and legislative challenges to be met if this manpower resource is going to be made available to community programs.
   a) The education of lay and professional leaders in local programs on the availability of this resource.
   b) The integration of supplementary education and skill into the profession necessary for the full utilization of the technician by the patient in the community.

Senate Bill 677: This organization as one of the professional organizations of people who care for the mentally ill should join with other professional organizations to study this bill and make recommendations for revisions.

We who have dedicated our professional lives to the care and treatment of the mentally ill should not concern ourselves solely with the mechanics of financing programs. Experts will do that. Nor should we concern ourselves with the esoteric philosophical preoccupations of law. Other experts will do that. Nor should we concern ourselves with the same basic question that the authors of the bill themselves are sincerely concerned with, namely, "How can this bill be made so that it will be effective in bringing services to the mentally ill with a minimum of delay, despondency, and despair and a maximum of health and hope?"

* Lanterman-Petris-Short Act (Mental Health Act of 1967) provides for changes in the commitment system for mentally ill to prevent inappropriate and indefinite commitments. Other portions of the Act encourage the development of local services and foster a greater integration of state hospitals and local programs.

SYMPOSIUM: INTERPRETING FEDERAL AND STATE REGULATIONS WHICH AFFECT STAFFING STANDARDS FOR NURSING SERVICES IN STATE AND LOCAL FACILITIES.

MODERATOR: *Leland F. Erbacher*

MEMBERS:

Howard A. Worley

Ralph Zeledon

Moderator Erbacher is employed by the Training and Research Division, Personnel Office, of the Department of Mental Hygiene of California.

INTRODUCTIONS TO SYMPOSIUM

---

by Howard A. Worley

Mr. Worley, a graduate of Stanford University and its School of Business, is Chief of the Bureau of Licensing and Certification for the California Department of Public Health. He has been with the Department since 1949. His Bureau is responsible for the licensing of more than 1900 health facilities and for their certification for participation in the state and federal medical care programs.

The title for the subject matter being considered today suggests that the State requirements for licensure of health facilities and the Federal requirements for participation in the medical care programs are in need of interpretation.

These requirements indeed do need interpretation or at the very least—explanation. Words can mean different things to different people – and regulations must be set down in words.

By way of background, let me describe briefly how licensure requirements for health facilities are established. As you know, both the State Department of Public Health and the State Department of Mental Hygiene have responsibilities for health facility licensing programs. The Department of Public Health licenses hospitals, nursing homes, establishments for handicapped persons, certain clinics, home health agencies, and clinical laboratories; and by formal agreement with the State Department of Mental Hygiene, and subject to Department of Mental Hygiene requirements, the Health Department licenses and inspects alcoholism hospitals, long term facilities for the mentally ill and day care centers for the mentally retarded.

The Department of Mental Hygiene has sole licensing responsibility for psychiatric hospitals, day treatment hospitals, children's treatment centers for the emotionally disturbed, family homes for mentally ill, resident schools for the mentally retarded and nurseries for the mentally retarded.

There is a Hospital Advisory Board, appointed by the Governor, which advises the State Department of Public Health regarding reasonable rules and regulations for the hospitals and nursing homes licensed by the State Department of Public Health. This Board holds three to four public meetings each year to consider proposals for changes in the requirements for the licensure program. The Recommendations of the Advisory Board must be adopted by the State Board of Public Health, in public hearing, before filing with the Secretary of State as part of the California Administrative Code.

In practice, proposals which are considered by the Hospital Advisory Board are discussed with the professional organizations concerned: the California Hospital Association, the California Association of Nursing Homes, and the California Medical Association. Each of these organizations has a consultant to the Department on matters regarding the licensure program. Additionally, special areas of

interest are discussed with the respective professional associations, particularly the California Nurses' Association regarding nursing services and the California Council, American Institute of Architects regarding construction requirements. Discussions are also held with the Association of Medical Records Librarians, Association of Hospital Pharmacists, Physical Therapy Association and others regarding specific problem areas.

The State Department of Mental Hygiene employs similar procedures for developing licensure requirements for health facilities under its jurisdiction, except that no provision is made by law for an advisory board. Special committees serve this function on an informal basis.

Each of the classifications of facilities licensed by the two Departments have differing staffing requirements for nursing and other personnel. It would be confusing not only to you but to myself if I attempted to recite these requirements in detail. However, I would like to mention a few basic requirements and confuse you only with the specific requirements for nursing homes and long term facilities.

All facilities are required to have sufficient qualified personnel to provide care to patients in the institution both day and night. The actual number of nursing personnel which must be employed involves a judgement factor and can vary with the number of patients being cared for, the specific needs of those patients, the qualifications of the nursing personnel employed, and the layout or arrangement of the physical plant.

Hospitals – licensed by the Department of Public Health and psychiatric hospitals licensed by the Department of Mental Hygiene – require a registered nurse on duty at all times, with additional qualification by education, training and experience for the director of nurses or supervisor in larger institutions.

Public health nursing homes of 10 or fewer beds must have at least one nurse who is a registered nurse, a licensed vocational nurse or a person who is qualified by training and experience to supervise the nursing care in the institution. The adequacy of this training and experience is determined by the Department. Nursing homes of 11 to 25 beds must have a registered nurse, a licensed vocational nurse, or a nurse graduated from a school of nursing who the Department determines has sufficient training and experience to assume the responsibility of supervision of nursing care.

Nursing homes of more than 25 beds must have a registered nurse on duty during the day shift responsible for supervision of nursing care. Additionally, nursing homes of 60 to 99 beds must have either a registered nurse or a licensed vocational nurse on duty during the remainder of the day and night. Nursing homes of 100 or more beds must have a registered nurse on duty at all times.

Mental Hygiene long-term facilities have similar yet different requirements. The facility of 25 or less beds must have a registered nurse, a graduate nurse, a licensed vocational nurse with two years experience subsequent to licensure, or a certified psychiatric technician with two years experience subsequent to certification - to be responsible for supervision of nursing services during the day shift. Facilities of 26 or more beds must provide a registered nurse, during the day shift responsible for supervision of nursing services. Facilities of 100 or more beds must have a registered nurse, a graduate nurse, a licensed vocational nurse, or a certified psychiatric technician on duty at all times. Facilities of 200 or more beds must have a director of nursing services who is a registered nurse qualified by education, training, and experience in nursing administration.

At this point I can anticipate a question running through your minds. Why do the Public Health requirements exclude mention of certified psychiatric technicians?

Two other state agencies now become involved - the Board of Nursing Educa-

tion and Nurse Registration and the Office of the Attorney General. Section 2728 of the Business and Professions Code - part of the Nursing Practice Act - states:

> "If adequate medical and nursing supervision by a professional nurse or nurses is provided, nursing service may be given by attendants in institutions under the jurisdiction of or subject to visitation by the State Department of Public Health, the State Department of Mental Hygiene or the Department of Corrections.
>
> "The Director of Mental Hygiene shall determine what shall constitute adequate medical and nursing supervision in any institution under the jurisdiction of the State Department of Mental Hygiene."

The same Act defines a professional nurse as one licensed as a registered nurse in California.

The Board of Nursing Education and Nurse Registration has interpreted this to mean that in facilities licensed by the State Department of Public Health, nursing services may be given by other than a registered nurse only if supervision by a registered nurse is provided. This produces an apparent conflict for nursing homes of less than 26 beds which are not required to provide a registered nurse supervisor. The Board of Nursing Education and Nurse Registration together with the California Nurses' Association has requested that the regulations be amended to require a registered nurse supervisor regardless of size of the nursing home. Such a proposal was reviewed by the Hospital Advisory Board in September and was referred to the Health Department staff for further study.

The present requirements were adopted in 1959 following extensive discussion by the Hospital Advisory Board. The question of the certified psychiatric technician was not considered at that time. That the certified psychiatric technician should be considered as the equivalent of the Licensed Vocational Nurse has been posed since. Such equivalency has, however, not been specifically proposed as an amendment to existing requirements. I can only point out that the education and experience requirements for certification are different than required for the licensed vocational nurse, and that the psychiatric technician who meets the education and experience requirements may qualify to take the examination for licensure as a vocational nurse but only until next year, unless the law is extended.

If I may digress for a moment. Although there is no specific mention of the duties of the nursing supervisor in regulations or requirements, she is expected to perform certain functions in the nursing home. A high level of training and experience is necessary to perform these functions adequately. Let me mention a few of her duties:

1. Developing and maintaining nursing manuals.
2. Writing and updating job descriptions for nursing personnel.
3. Recruiting and selecting nursing personnel.
4. Assigning and supervising all nursing personnel.
5. Participating in patient care planning and job analysis.
6. Coordinating the various patient care services.
7. Planning and conducting in-service programs.
8. Determining the assignment of patients in the facility.
9. Delegating the responsibility for carrying out the patient's nursing care plan and reviewing the plan with the person to whom the duty was delegated.
10. Making daily rounds, visiting each patient, reviewing clinical records, medication cards, and staff assignments.

The basic statutory requirements for nursing services in extended care facilities for participation in the Federal Medicare program are that at least one registered nurse be employed full time in the facility and be responsible for the

nursing service, that a registered nurse or licensed vocational nurse be on duty at all times to be in charge of nursing activities, and that sufficient nursing personnel be on duty at all times to meet the total needs of patients.

Nursing personnel for determining adequacy in numbers includes registered nurses, licensed vocational nurses, aides and orderlies.

In addition, the facility must meet the State's licensing standards whether subject to licensure or exempt. State licensure requirements exceed Medicare conditions of participation for nursing services in one area only, in that nursing homes of 100 or more beds are required to have a registered nurse on duty at all times.

For the State Medi-Cal program - at the present time - the only requirement for participation as a nursing home is that the facility be licensed by the State Department of Public Health or the State Department of Mental Hygiene or be exempt from licensure. Further requirements, to be effective January 1, 1968, are essentially the same as for Medicare for nursing services, or, provided the State Department of Public Health determines by November 30, 1968 that the facility shows reasonable expectation of meeting this and other standards, by January 1, 1969.

The requirements for Medicare and for Medi-Cal for hospitals owned and operated by the state are the same as for non-state hospitals. However, a problem appears to arise. Hospitals accredited by the Joint Commission on Accreditation of Hospitals by Federal law meet the conditions of participation for hospitals if they have an acceptable utilization review mechanism, and in the case of psychiatric hospitals meet certain other conditions regarding medical records and social services. All of the State Hospitals, except those operated by the Department of Corrections, are certified to participate in both programs for hospital services.

The hospitals operated by the State Department of Mental Hygiene are currently certified as psychiatric hospitals. The provisions of the Federal Medicare Program permit the psychiatric hospital to have a "distinct part" and be certified either as a general hospital for medical-surgical services or as an extended care facility providing skilled nursing services, if the distinct part meets the conditions of participation. If so certified, the distinct part is also eligible under the Medi-Cal program.

At the present time it is unclear regarding the eligibility of hospitals for the mentally retarded to participate either in Medicare or Medi-Cal other than for a distinct part certified either as a general hospital or as an extended care facility.

The Departments of Public Health, Mental Hygiene, and Social Welfare and the Office of Health Care Services are working together closely to attempt to solve the problems both of eligibility of the hospitals and eligibility of patients. We hope that a satisfactory solution can be arrived at which will be acceptable to the Federal agencies concerned.

In closing I would like to leave a few statistics with you.

In 1956 the Health Department licensed less than 1,000 facilities with a capacity of 57,000 beds. Today, including the mental health facilities, the Department licenses more than 2,000 facilities with 150,000 beds. The bulk of this spectacular increase has been in nursing homes, which added approximately 600 facilities and 50,000 beds during the 11-year period.

While we don't have complete information on nurse staffing, some sampling information on nursing homes is of interest. Surveys of nursing homes in 1961, 1964, and 1966 indicate that nursing personnel employed have kept pace with the increase in number of beds.

The table below shows the trend in staffing nursing homes.

Estimated Number of Nursing Service Personnel (Full time equivalent) in Nursing Homes

Year	RN	Graduates	LVN	Other	Total	Beds
(March 31)						
1961	700	260	480	5,400	6,840	18,778
1964	1,390	360	920	8,800	11,470	36,351
1966	2,100	100	1,400	15,600	19,200	61,736
(Sept. 30)						
1967	2,500	100	1,600	18,600	22,800	61,229

by Ralph Zeledon

Mr. Zeledon, Coordinator for Medi-Care for the California Department of Mental Hygiene, is a graduate of the University of Southern California. Mr. Zeledon was awarded a Master of Social Work degree from the School of Social Work of Los Angeles, and is a member of the Academy of Certified Social Workers. He was formerly associated with the Economic Opportunities Council.

Perhaps the best way to approach this subject is to give you a brief description of my job; then the history of the Department of Mental Hygiene in regard to the Medicare - Medi-Cal programs; and finally bring you up to date where things now stand and present goals and complications.

Briefly, the Coordinator of Medicare Services coordinates the Department's program for securing benefits which are available under the Federal and State Medicare laws and regulations; analyzes and evaluates Medicare legislation, rules and regulations to determine benefits available to mentally ill and mentally retarded patients and types of services required for participation in the Medicare program; and proposes departmental policies and procedures for securing benefits for, and providing services to patients.

Medicare is a nationwide program of medical insurance for persons age 65 and over. It is related to the Social Security Benefits Program and is an insurance program which limits benefits to a 90-day spell of illness or hospitalization. Medi-Cal or Medicaid as it is known nationally is a Federal encouragement for states to launch their own programs in which the Federal Government will pay 50% of the cost. It is available for all four categories of public assistance and any medically indigent who can meet the criteria of a welfare category other than income. A regular medical hospital can bill for eligible Medi-Cal beneficiaries in any age group. However, with the psychiatric hospital there is what is known as a psychiatric exclusion which limits payments to persons age 65 and over.

Medicare or Title XVIII pays almost 100% of the cost for prescribed periods when the patient is eligible. Medi-Cal or Title XIX is paid out of the Health Care Fund and then reimbursed 50% federally. Therefore, half the cost is Federal and half is State. But the Department of Mental Hygiene does not keep any of

these payments as it operates on an allocated budget. Medicare payments are forwarded back to the Health Care Fund. Therefore, this program within the Department of Mental Hygiene represents a shifting of cost from the State to the Federal Government. The money does not go back to the hospital to raise the level of care. There are some minor benefits to the hospital in meeting Federal requirements.

To receive Medicare payments, a hospital must be approved as a vendor of services by the Social Security Administration. The Social Security Administration does not have the staff within each state to survey hospitals and ascertain which hospitals meet the Federal requirements and which do not. Therefore, each state designates a state agency to act in this manner in behalf of the Social Security Administration. The Federal Government has spelled out the specific requirements in the booklet entitled "Conditions of Participation for Hospitals". One of the requirements which must be met is condition Number V for the Nursing Department. It reads as follows *"The hospital has an organized nursing department. A licensed registered professional nurse is on duty at all times and professional nursing service is available for all patients at all times."* If a facility or part of a facility is to be considered an extended care facility, it must meet the following requirement: *"The extended care facility provides 24-hour nursing service which is sufficient to meet the nursing needs of all patients. There is at least one registered professional nurse employed full time and responsible for the total nursing service. There is a registered professional nurse or licensed practical nurse who is a graduate of a state-approved school of practical nursing in charge of nursing activities during each tour of duty."* However, if a hospital is accredited by the Joint Commission on Accreditation of Hospitals, it is presumed to meet all of the requirements with the exception of Utilization Review. *This is a critically important distinction.*

In 1956, the Department of Mental Hygiene requested that all 14 State hospitals and the 2 neuropsychiatric institutes be approved as psychiatric facilities. All were approved on the basis of being accredited.

In California Department of Mental Hygiene hospitals, there are approximately 13,000 mentally retarded patients. Of these, approximately 177 are age 65 and over and qualify for Medi-Cal benefits. If these hospitals were classified as medical instead of psychiatric, the psychiatric exclusion for patients under age 65 would not apply. There are approximately 7,000 patients between the ages of 18 and 65 who could meet the criteria of the Aid-to-the-Disabled program. The potential revenue here is for between $2.5 and $3 million per month of which 50% would be paid for by the Federal Government.

Therefore, the Department of Mental Hygiene asked for a change in classification for hospitals for the mentally retarded from psychiatric to medical hospital. This request was made in August 1966. The Social Security Administration is admittedly apprehensive about changing the classification of the hospitals for the mentally retarded. The entire Title XIX program has cost far more than expected. Perhaps this is why the Social Security Administration has never made a decision on this matter.

When the Department of Mental Hygiene requested reclassification of the mentally retarded hospitals, a difference of opinion developed between the Department of Public Health and the Department of Mental Hygiene. Public Health felt that the hospitals do not really meet the requirements for a medical hospital and that they would have to be surveyed to determine the conformity with the Federal requirements. Whatever portions did not conform would be designated as extended care facilities or simply not included in the program. The Department of Mental Hygiene maintained that accreditation was sufficient and the hospitals did not have to be sur-

veyed. The impasse was not in the best interest of the State. Therefore, in an effort to resolve the differences, the Department of Public Health agreed to survey one hospital to determine how far apart the two Departments were in their thinking but to take no action on the survey without Department of Mental Hygiene approval. This was done at Fairview State Hospital on July 25-26, 1967.

The findings of that survey were that under one classification or another every bed in the hospital could be approved if 10 registered nurses and 10 LVNs were added to the staff. The Department of Mental Hygiene asked the State Department of Public Health to survey the rest of the hospitals for the mentally retarded and present their findings to Dr. James Lowry, Director of Mental Hygiene, for his consideration.

Suddenly, a barrage of telephone calls were received at the Department of Mental Hygiene Headquarters protesting the assignment of the additional staff. Dr. Lowry stated that there would be no changes until he could see the total recommendation. The surveys were completed and the findings presented on September 20. At that time, the administrative staff at the Department of Mental Hygiene recommended to Dr. Lowry that the Department hold its ground and continue to seek approval of the hospitals on the basis of their being accredited.

We are still in the midst of negotiations. The hospitals may be approved by the Social Security Administration on the basis of accreditation. If so, there will be no need to alter present staffing patterns to qualify. If not, I cannot foretell the outcome.

It behooves us to look at the realities which will have to be considered in making a decision. To decide not to participate in the Medi-Cal program will mean the State's forfeiting between $12 and $25 million per year of Federal money. This is where the matter stands now.

In concluding, I would like to comment on the effect I believe these Federal programs will have on the psychiatric technicians. The decreasing mentally ill population is fact, not prophecy. The question is to what extent will it decrease. I think there is little doubt but that we will see a similar de-population movement of the mentally retarded. This poses two questions:

1) What direction is the mental health movement taking in California?

2) How do we enable staff occupationally to fit in with the new direction? It seems to me that the future direction of mental health treatment in California is spelled out in the Lanterman-Petris-Short Act.

Every effort will be made to provide treatment on a local level so as to avoid state hospitalization. The local community then is where there should be job openings for people with psychiatric experience. I would like to quote from (Division 5, Part 1, Chapter 1, Section 5008(c) the Lanterman-Petris-Short Act in describing these local facilities:

"Intensive treatment shall be provided by properly qualified professionals and carried out in facilities qualifying for reimbursement under the California Medical Assistance program or under Title XVIII of the Federal Social Security Act and regulations thereunder."

Therefore, the question of Federal requirements will be faced in the community as well as possibly within the State hospitals. I wonder about the possibility of psychiatric technicians pressing for an LVN equivalency rating or some arrangement which would enable them to move into the positions which will be created by these local facilities.

Legal Aspects Of Utilization Of Psychiatric Technicians In Mental Health Services

by Robert Thorn, J. D.

Thorn, an outstanding authority on forensic psychiatry who practices in San Diego, California, is that county's Chairman of the Mental Health Advisory Board, a member of the Governor's Advisory Committee on Mental Health, President and Board member of the Vista Hill Psychiatric Foundation, and has served on the Medical - Legal Institute faculty of the Western and the California Hospital Associations. He has also conducted legal seminars for the National Association of Private Psychiatric Hospitals.

In our modern society we frequently hear cries of loss of identity or lack of identification. From the standpoint of professional identification in the legal sense, the psychiatric technician might be classified as the all-time loser. While the "Psychiatric Technician Law" has been part of the California Codes since 1959, little has been gained under this statute toward legal identity as a true professional in the healing arts. This may be primarily due to the fact that the "Psychiatric Technician Law" is a certification act as distinguished from a licensing act.

The distinction between the two basic types of legislative recognition, i.e., those of certification vs licensing, is primarily this: Under the certification act, as in the case of the psychiatric technician, any individual, regardless of training or experience may hold himself out to be a psychiatric technician and engage in such practices as are customarily performed by psychiatric technicians so long as he does not use the term "Certified Psychiatric Technician".

In the case of licensing, as in the professions of law and medicine, not only is one prohibited from using the term "lawyer" or "physician", but one is also prohibited from engaging in the practice of law or medicine without a valid State license. Historically, professional recognition has come from licensing and from additional standards of competency developed by an association of those engaged in the profession such as those being developed by your association. The latter without the former, however, has always been legally ineffective. The psychiatric technician in California therefore remains at most a civil service classification without true legal identification.

One thing that can be said about the laws of the State of California and the administrative rules promulgated under such laws is that they are consistent in the non-recognition of the psychiatric technician. A two-months intensive study of such laws, rules and regulations of this State discloses that in no single instance outside of the "Psychiatric Technician Law" is a psychiatric technician recognized as even existing.

All portions of the California Administrative Code relating to professional standards for all types of medical institutions, from the nursing home or sanitarium to the general hospital, fail to set forth a single mention of the psychiatric technician, while at the same time recognizing the professional status of the Licensed Vocational Nurse. It is particularly upsetting to find that in the administration rules for staffing under the Short-Doyle Act, the categories drop from the registered nurse to attendants. Until the implementation of titles 18 and 19 of the Social Security Act, better known as Medicare and our Medical programs, little or no problems were encountered from the hospitals' standpoint in staffing standards as they were primarily free to prescribe their

own rules within the somewhat vague standard set forth by the Joint Commission on Accreditation of the A. M. A. and A.H.A.

Under the Nursing Practice Act, the Directors of the Departments of Mental Hygiene and Public Health were given carte blanche authority to determine proper nursing staffing procedures in state hospitals. While currently Federal Government is accepting accreditation by the Joint Commission as satisfactory proof of proper staffing for Medicare and Medi-Cal, there appears to be a great fear on the part of the hospital administrator that the Federal Government will in the near future impose greater and much more stringent staffing requirements.

While, as mentioned, California is consistent in its non-identification of the psychiatric technician, the Federal Government follows a great path of inconsistency in this regard with its various programs.

In its 64-page book of rules for conditions for participating hospitals under Medicare, the psychiatric technician is mentioned only once and this is in regard to the authorization to give medications under the direct supervision of a registered professional nurse in a general hospital. It is somewhat discouraging to find that while these rules prescribe special staffing procedures for psychiatric hospitals requiring utilization of milieu therapy and the team approach to treatment, no reference is made to the psychiatric technician.

The highest governmental authority for the interpretation of these rules as applied in the State of California has publicly stated that while the licensed vocational nurse can be recognized in the staffing pattern, of a hospital, the psychiatric technician, whether certified or not, cannot receive such recognition as they are *"not licensed personnel"*. The identical procedures and applications are utilized in Medi-Cal as well as in the Medicare program. Conversely, in the federally sponsored Home Health Program, reimbursement may be obtained for performance of services by psychiatric technicians. Again under the Community Mental Health Centers Act, the National Institute of Mental Health recognizes the utilization of the psychiatric technician and will reimburse a hospital for services performed by the psychiatric technician under its federal staffing grant.

With the growing support of programs in the non-governmental psychiatric hospital and mental Health Center by both the State and Federal Governments, there obviously is a need for the increased utilization of the psychiatric technician in such facilities.

During the last year, many administrators and directors of nurses in such hospitals, have expressed concern about the use of psychiatric technicians for performing nursing services in relation to liability for malpractice. We have pointed out to such individuals that if a negligent act is performed by an employee of the hospital whether it be a psychiatric technician, a licensed vocational nurse, or registered nurse, the liability is identical. In the absence of the negligent act by such employee, the hospital faces liability only if the employee is required to perform a service for which he has not been trained. In other words, we see no hazard whatsoever in the utilization of the psychiatric technician within the limits of his training.

I am sure that most of you here today are saying, "Well, we recognize our lack of identity under both State and Federal law, but what can we do about it?" What constructive steps can be taken to gain professional recognition in the eyes of both the State and Federal Government. I would suggest consideration of the following measure.

First would be an appeal to the Secretary of Health, Education, and Welfare to establish and recognize the psychiatric technician as an integral part of the treatment team in milieu therapy, whether it be in a psychiatric hospital or in a general hospital providing psychiatric care. The recent amendments to the Social Security Act give the Secretary a great deal of

discretion in setting forth the rules and regulations applicable to the Medicare and Medi-Cal programs and he fully has within his power the right to give such recognition. Should the Secretary be non-responsive to such an appeal, we would suggest that a Joint Resolution of the Congress be sought, expressing congressional opinion that the psychiatric technician be recognized in a professional status under all of the various federal programs for the treatment of the mentally ill and mentally retarded.

Finally, and perhaps the most important, you should consider proposing a proper licensing statute defining the scope of the practice of the psychiatric technician and prohibiting practice of psychiatric technology except by those persons meeting proper standards of education and experience.

I think that the average citizen in California might be somewhat astonished to find out that someone who is entrust - ed with the great responsibility of direct care to the mentally ill performs this service as an unlicensed individual, while no-one can cut your hair, or press your pants in this State without being licensed. We would question whether such proposed licensing legislation should be subservient to the Nursing Practice Act. The services rendered by the psychiatric technician seem to be by nature much broader in their scope than normal nursing practices, particularly in the application of other social sciences.

As many of you are aware, the legislature amended the "Psychiatric Technician Law" so as to place the psychiatric technician in a direct line of communication with the physician as distinguished from the former requirement that he be subordinate to a registered nurse. This, at the request of the Department of Mental Hygiene, was unfortunately vetoed by the Governor. We do feel, however, that in the coming year with proper explanation to the administration, such legislation might be successful.

In a recent meeting sponsored by the California Hospital Association, a leading hospital administrator stated that the registered nurse has reduced her role to that of an injection giver and that others were performing her previous service of direct patient care. If others like the psychiatric technician are in fact performing such service, why should they not be licensed, recognized and identified?

SEE APPENDIX I:
ALL THAT GLITTERS MAY NOT BE GOLD

Private Psychiatric Hospitals

by Arthur Jost

Arthur Jost, Administrator of King's View Hospital, Reedley, California, is President of the California Hospitals Association and Chariman of the California Committee of the National Association of Private Psychiatric Hospitals. He has long been lauded as a leading authority in planning and development of psychiatric facilities throughout the country.

The California Hospital Association has historically been related to general hospitals. Today, the administrators are being urged by the A.H.A. as well as by the C.H.A. to establish community comprehensive centers which would include care of the mentally ill. Some of us who have for many years been active in the C.H.A. are quite concerned with the Health Care Fields movement into the problems of the mentally ill and mentally retarded.

First, I want to go a little bit into my background so that you can appreciate some of my perspectives regarding personnel. About 20 years ago, after serving for 3 years in a state hospital both in personnel work and ward work, I was transferred to the headquarters of the Mennonite Hospital in Pennsylvania.

Through a great deal of survey and search work the Mennonite Church, which has operated many hospitals, nursing homes, and old people's homes, felt that it should move into the area of providing institutions for the mentally ill. We had one such institution located in the Crimea in Russia. Many of our people lived there, and one of the bright spots in their history was the establishment of a 100-bed, non-sectarian general hospital. This heritage, plus experience during World War II in civilian public service, prompted the church to move into a mental health program. At that time, 1946, it projected three small psychiatric hospitals: one near Hagerstown, Maryland, one in Newton, Kansas, and one in Reedley, California. I assisted in the establishment of a 40-bed hospital near Hagerstown which is considered to be a comprehensive mental health center. I then assisted in the establishment of Prairie View Hospital in Kansas. One of the very significant things this hospital is doing is working through a state hospital in the implementation of a large mental care research program. We also established King's View Hospital in 1951 and today this hospital is a 55-bed facility. We also moved into the Day Care program in Elkhart, Indiana. Today we are operating a rather large program there with placement homes right in the community. There, some patients from out of town can now stay overnight.

Our most recent completed project is at Bakersfield. On the invitation of the Memorial Hospital Board in Bakersfield, our Board of Directors duplicated King's View Hospital there and it has been in operation for one year. This 25-bed hospital will be expanded to 50 beds.

The real motivations for this dynamic program in the United States in 1946 were diverse. One was to provide care for our members. This element today constitutes only about 2 per cent of our patient load. We made it nonprofit and were able to establish a reasonable fee. Then, the church, through its colleges, church programs and publications, became interested in learning what it could about the potentials in the field. We felt that the hospital itself could be sort of a laboratory where we would build experience that could help us progress. There was also another motivation which came

out of our public service experience. This was to utilize the large resources of personnel which we discovered to be available. Thousands of young people have worked in these institutions. It is very heartening to see how many of these youngsters, having completed a year or two, have gone into the various professions. We have today a large number of psychiatric social workers in our church, a few psychiatrists, some nurses, and many psychiatric technicians who have gone into these fields professionally because of the experiences they had in our institutions. I might add here, parenthetically, that back in about 1950 or 1951, I also assisted in opening certain other services at Mendocino, Camarillo, Atascadero, and a few other State Hospitals where some of our students and young personnel were working alongside the psychiatric technicians.

At Kings View Hospital we have expanded to operation of out-patient clinics in Hanford and Visalia. At King's View Hospital we are widening our sphere of activities. First of all, we are interested in direct care to in-patients. Up to 1955 we were pretty well satisfied that our program would be an in-patient service program. But later, with development of many of the drugs, we broadened our vista and became involved in non-direct services in communities. So today we are interested in both, and the in-direct services are being advanced in Visalia and Hanford. We are also very much interested in regional planning. In fact, we are very much involved in it. I believe regional planning is rapidly coming into its own in the psychiatric field. Just recently there was federal legislation which has been implemented in California and other states. This will provide the means of giving more attention to psychiatric facilities and planning. We are now exploring possibilities in Visalia to provide in-patient services for acutely disturbed patients. In Bakersfield, we will also be involved in regional planning with Kern View Hospital.

At King's View Hospital we now have an arrangement with Fresno State College to train clinical psychiatrists in limited fields with limited scope. Once we have the University closer we will proceed further into this field. We hope to be working shortly with Fresno State College in psychiatric social worker training. We are not now training psychiatric technicians.

Talking just a moment now about training for the future: All of our centers, King's View Hospital, Kern View Hospital, and other private psychiatric hospitals throughout the country will need to get much more actively involved in training programs. The National Institute central office, which has been instrumental in assisting us in obtaining Federal Grants continually emphasizes that we must look forward to future training programs. As we develop this further in the valley, we hope to be more involved in training psychiatric social workers, nurses, public health nurses, and eventually psychiatric technicians.

I recall a number of years ago when he was Director of the Department of Mental Health Dr. Cohan said that California would have the first training program for psychiatric technicians in the country. So I am justly proud of these service units that we established throughout the state mental health programs, extensions which evolved out of Camarillo and other state hospitals. When this program got underway, a program that many of our young people established, the results included the 300 hours of training which facilitated installation of the direct-training program. About that time, some 10 years ago, I received a telephone call from someone in your association who wanted to discuss the possibility of setting up a section in the private psychiatric health field for training psychiatric technicians. But, unfortunately, we never got beyond the discussion stage. We have since witnessed in California an active program of training for psychiatric technicians. Unfortunately, this trend has not permeated the non-profit, private sector. We can now look

at such possibilities more realistically.

I am going to shift here and ask questions about the future of the mental health field and mental health programs in general. We must know: Where will the action be? Many of you have been interested in the Mental Health Act of 1967. I understand by way of the grapevine and through communication channels of the private psychiatric hospitals that there is a great deal of interest nationally in California's action during this last year. Under terms of this bill, which changes commitment procedures in California approximately one year from today, we will no longer see large numbers of people being committed to state institutions. We will see further implementation whereby local communities will need to contract with state hospitals if they wish to continue to make services available by state institutions. Even though financing is not spelled out too clearly, we must ask ourselves what happens when large amounts of money leave the county in order to provide services to county residents in state institutions. How will this work? How will the governing body of the county react to this, and how long can it go on? How active will state hospitals be? How rapidly will we move into these programs in the local community?

Assemblyman Frank Lanterman, as you know, is one of the chief authors of the bill. What Mr. Lanterman wanted to achieve was a change in the commitment laws. He simply wanted to reduce commitments. In visiting with him the other day he pointed out to me again how sincerely he wants to see this done in California so that other states can follow our example. I think we must understand that even though the bill doesn't include all the methods of implementation, and even though there will be regulations that are not going to suit many of us, the central kernel with which we can find no argument is the one of treating psychiatric patients by moving them into community treatment centers. I believe we are going to see from Mr. Lanterman and others a very heavy emphasis on compliance with this bill.

I think it is very easy to see the implications of this Act. No longer will we commit patients to the state institutions through judicial procedure. Local treatment will be much more profitable and it will become, for local and county officials and other people in the community, a more palatable system.

We want to go much further than simply offering jobs or, if you are a psychiatrist, simply practicing psychiatry. We need a much more comprehensive program. Where will the patients be in 5 years? And where will the technicians of the future be trained? I am very closely associated with Reedley Junior College. We know that colleges today are seeking additional programs to assist the community. It does seem that very soon we should be able to get junior colleges to supplement training programs which are going on in state institutions today. It doesn't mean that we need to replace state hospital training programs, but we need to supplement them. We need to have similar programs right in the community. A lot of youngsters who are not going to a university or a 4-year college would go to a junior college if they could find something there to challenge them and lead to a good job serving the community when they finished. I think this could be made into a very practical program for either a four-year or two-year college. Having been quite close to this for over two years, and having discussed this type of program with Reedley Junior College officials, I believe we could move ahead in this area. Another question is: How do psychiatric technicians relate to the R. N. or the medical personnel. Mr. Thorn's paper touched on this in a very positive and very constructive way today. I was involved in a CNA study and the presentation of the urgency act to keep the certification program going for the psychiatric technician. For me this was a very excellent experience. I became further acquainted with the needs of the psychiatric technician and gained a new appreciation for them. I appeared before

a hearing in Stockton on behalf of the P.T.'s at one point. But what we have in Mr. Thorn's paper would go even further.

At this point I would like to go into some of the problems we are having in small, private psychiatric hospitals. In our program we have about 120 employees, and you can well understand that many of them are psychiatric aides – we don't use the term psychiatric technician. We do have a classification and salary structure for psychiatric technicians written into our personnel programs and policies, but we have never hired one. We didn't understand the need for them.

At Carmel about three months ago we participated in a meeting of the California Committee of the National Association of Private Psychiatric Hospitals, and finally realized how many hospitals utilized the psychiatric technician. One hospital administrator spoke of his doubts about using P.T.s in private hospitals. In defense of the psychiatric technicians there were three or four hospital administrators who lauded the extra background and training as well as the competence of the P.T.s they had hired. I could see from the conversation that there were many ideas on how the P.T. can be used in psychiatric hospitals and can be used in community centers. We have one on our staff at King's View but he is working in our two-county hospital in Hanford, assisting with work which perhaps some social workers or public health nurse could do. But this man does it very well. All our personnel, our social workers, psychiatrists and psychologists have agreed that he does a mighty fine job. He's got their blessing.

The people we pick to work in our hospitals are housewives – people who have raised a family and have known something about human relationships. They are warm and like people. We have about 78 of these, none of whom has had formal training. This puts a tremendous load on our supervisory personnel. They have to train them to work with psychiatric patients. I don't think this is right. I think these people should have training when they come to us or at least there should be a parallel training going on and a certificate or license should be issued when they have been trained. I have felt this for a long time, having had experience with recruitment and staffing of a private hospital. The people who do this supervisory work and training are another problem. Finding psychiatric nurses who are qualified today is like finding a needle in a haystack. In Bakersfield today we have a psychiatric nurse who is a good trainer and a good supervisor. So we have one. But in some of our other hospitals, we have picked up R. N.'s who have had little, if any, psychiatric training to be the trainers and the supervisors. You can see what a tremendous burden this puts on the psychiatric social workers, psychiatrists and other people who are really trained in the psychiatric profession. There is still this great lack of qualified trained manpower. I would suggest that somehow we get together – that somehow we find a way that PT's can work into the private sector. We are going to be moving into community health centers very rapidly. I suggest that in five years community mental health centers, general hospitals and private hospitals are going to move a long way toward shorter treatment periods. Patients will leave the hospital for the community but they will still need our personnel outside of the hospital or in the clinic. Some of us are rushing to the NIMH training program to prepare ourselves for this new frontier in staffing.

We want people in our program who can, when they come to us, show us their credentials so that we can employ them as supervisors and administrators in our hospitals knowing they have been trained. I am certainly not down-grading the staff we have. I think they are doing a magnificent job. As I said at the outset, in the last 20 years we have seen a thousand of these young people make a contribution, and at the same time they have been helped to achieve greater human understanding and have been guided into the mental health program. This is great,

but if we expect nurses who are RN's, doctors who are M.D.'s and L.V.N.'s with licenses to perform as licensed professionals, PT's, too, should have licensing. On the other hand, we should not expect a great "Amen!" from all these other professions. They should certainly say "Amen!" to new frontiers, new dialogues, and new approaches because they are coming.

Programming For The Future

Senator Petris, a Stanford Law School graduate, represents Alemeda County and has been a member of the Legislature since 1958. He co-authored the Mental Health Act of 1967, developed while he was Chairman of a Senate Committee with jurisdiction over the Mental Hygiene and Social Welfare Departments. Known for his legislation of social significance, he is also a member of the Public Health Committee.

As an official member of the official family of the state of California, representing the legislative branch, I extend a hearty and warm welcome to all our visitors from out of state.

Before I discuss the subject which has been assigned to me, I want to make two or three personal comments. One is, I want to congratulate your association on your choice of a representative in Sacramento, Mr. Bill Grimm. He didn't know I was going to say this, and it would be easier to say if he weren't here, but he's done an outstanding job, and of course you who are active in your association know about it, but I think this word should be transmitted to all of your members here and at home. The task of representing an organization of this kind is a state-wide job and an extremely difficult one. Any of you who have dealt with any of us know that every single one of us is egotistical. That makes it difficult right off the bat. If we weren't, we wouldn't offer ourselves for public office. Of course we go into it because we are concerned about the problems of people, and we are hoping to offer the best solutions we know to take care of these problems. But we also go in because of the attention we get. We like to be included in the center of the spotlight from time to time. Basically, however, any politician who offers himself for public office has a deep liking for people. If we didn't, we wouldn't be in politics. There are those who say that politicians love mankind and hate people, but that's not true. Anyway, all of these things put together make the job of the legislative advocate a very difficult one. And it's extremely tough to try to get in to see all of these people who have important things to do about legislation. There are 120 of us and more than 500 legislative advocates. When you take all of us and count all the number of persons that try to see us and combine them with all of our visitors from home, you find that a a really effective legislative advocate has to be very nimble, he has to have a good personality, he has to know his subject matter, and most of all, he has to enjoy the confidence and respect and friendship of the members of the legislature. And I'm here to tell you that Bill Grimm is worthy in the highest degree. I think you should be very proud of the work he does for your group.

Secondly, I should let you take a peek with me, inasmuch as the subject that has been assigned to me is taking a look, at programming of the mental health picture for the future. But I can't talk about the future without talking a little bit about the past. Although I haven't been active in coming to your meetings or meeting with you as individuals, I want you to know that I've learned a lot about you and the things you are doing from Bill Grimm. I've also learned a lot about what you are doing, not as members of this organization, but as employees of our great state. You are working in an area which is one of the most difficult of all. I've gained a tremendous amount of admiration and affection for you as individuals by looking at your reports, by conferring with doctors with whom you work, and some of the people in the De-

partment of Mental Hygiene, and lastly, by checking the budget each year. It was my duty for about four years, as chairman of the subcommittee of Ways and Means which had jurisdiction over mental hygiene, to see what the budget provisions were going to be after the Governor submitted it to the legislature for the ensuing year. I've always been amazed that the State of California has been able to recruit as many persons in your field as we have through the years without paying much higher salaries, and without offering a lot of other fringe benefits that are available with other types of employment outside of state service. I always came to the conclusion that there must be a tremendous missionary zeal comparable with the clergy, our great teachers, and others to whom society has not yet demonstrated sufficient gratitude or sufficient understanding of the importance of the work they are doing as well as the extreme sensitivity and complexity of their jobs. If it is any comfort to you, I want you to know that I personally have that view, and I know many other members of the legislature do too. The problems, unfortunately, are that every time the budget session does come up, everyone is scrambling for that tax dollar, and it's very difficult to make the allocations that you want to make. I also want you to know that I personally, because of this knowledge, continue to admire you individually and as a group, and will continue to do every thing I can for you. I have had many fights in the past on this – to see that the salaries and the structure of compensation of our people who are working as psychiatric technicians in our state hospitals are continually upgraded. I feel sorry that it's not a lot better today than it is, but we haven't forgotten, although sometimes it seems that we have. It's just that other things get in the way, and appear a little more charming by virtue of the fact that they are in even worse shape. We get back to trying to pick through, and go from year to year with improvement in as many programs as we can.

Many people have heard some things about the Mental Health Act of 1967. It's a kind of milestone. We don't know exactly how it's going to work out. We are to some extent taking a chance on Congressional provisions, but in looking ahead, I wanted to make three or four points extremely clear which I think will link directly to your profession and your work.

Number one, I hope you don't feel that this bill was designed to dismantle state hospitals or close them and send all the technicians and other people working in the hospitals off to the wilds somewhere or to another area where they have not been trained to work. I know that Assemblyman Lanterman, who was principal author of the bill and introduced it in the Assembly, shares my view that we're not going to stand by and watch psychiatric technicians as a body disintegrate because we are trying to de-emphasize this enormous centralization of care for the mentally ill that we've had for many many years. I know that there is a major defect in the code now by virtue of the fact that psychiatric technicians are unique to the state hospitals. There are very few of you operating outside the state hospitals. You get all of your training in state service, and the various sections of the code which define what the psychiatric technician is limits it to state hospitals.

It seems to me that the state will not be meeting its responsibilities if we decide to decentralize to such an extent that a large number of psychiatric technicians have to follow a patient from state hospital centers to the local community without providing equal provisions in the code safeguarding the technicians' interests. I, for one, intend to see to it that this is done; I hope in this coming session. We must transfer the definition from state hospitals alone and expand it to include the same definition in all local mental health facilities whether they be public or private. I pledge to you that I am very much interested in that, and will work to get a bill through this

coming year. I have talked about it to Bill Grimm. We have at least another year to go – almost another year – before the Lanterman - Petris - Short bill is actually put into operation. I would hope that you can devote some of your time, at home in your local chapters, to assist with legislative recommendations that will make our transition smoother, and beneficial for both patient and the people who take care of the patients. You people, in my judgement, will really form the backbone of our entire state mental hospital system.

So, when we look at the future, we see, number one, a continued decentralization of care of mentally ill away from the large hospital centers to more and more treatment in the community. This trend was started with the original Short-Doyle Act of 1957. That measure provided for many improvements for the care of the mentally ill. We have managed to keep a lot of people close to home where they were able to visit with their families. And in many situations it has been clearly documented that the effect on the morale of the patient is such that he actually snaps back to normal a lot faster than he does far away where he feels that no one cares about him. He simply, in many cases, lost his will to live.

The first signs of looking into the future is the continuation of this development from the past. That is more and more decentralization to the extent that we can do it and still improve the service to the patient.

Along with that will be a change in the law so that the psychiatric technician and others who will be transferred to follow the patient as it were, will also maintain at, as an absolute minimum, the status they now enjoy, and we hope will be improved.

My prediction is that the status of the psychiatric technician will be upgraded rather than kept at the same level or down-graded even though people tell you now that they are going to try for salaries in a lower category of pay and lower category of medical hierarchy. There are two reasons why I tell you this. Not just because I'm a politician who is trying to please you, and I haven't even checked the roster to see how many of you live in my district. I say this for two reasons: number one, as the decentralization process is accelerated and more and more people are cared for locally, county after county will have to make provisions for some kind of hospitals or clinics where there is more than out-patient care. The patient will stay overnight, or for a few nights or for a few weeks. And more and more private facilities will be established. The pressure on local private facilities and public facilities from the families who are clamoring to see that their patients are cared for at home will rise in direct proportion to the number of patients that are taken care of at home, for better standards of training and pay for the people who help those who need the help. It is as simple as that.

The second reason of course is that those of us in Sacramento who are concerned about these programs are not going to abandon the people who have been so brave in helping us take care of the mentally ill. We are going to do our best to see to it, together with pressures from people at home, that some positive and constructive steps are taken in the current session. The key is working together toward this goal.

The third thing I see in development in the next few years is a continuation of the use of state hospitals. I know you've been told by many that they would be closed, particularly since the Administration first announced all those enormous cuts, which I opposed very strongly. Rest assured we do not intend by this bill, the Mental Health Act of 1967, to close up the state hospitals. There are different kinds of patients, as you all know better than I do. We intend to emphasize, and continue emphasizing, local treatment for those who are amenable to local treatment. But there are also many many other patients who simply will not be

able to respond and will have to go to state hospitals. People get the wrong impression, that because we want to keep as many of those patients at home as we can, we're going to automatically close up the hospitals. What is going to happen to those other severely ill and chronic patients who have been there for years? Are they just going to be tossed out somewhere? Of course not. As a matter of fact, one of the reasons that we feel we can help all the patients is that if we keep the newer milder cases active in their own community with local help, state hospitals to concentrate on those who need help the most.

There is another thing that I would like to predict for the future in connection with the role of the state hospitals; they will have changing functions. They will remain as important training centers for medical personnel who will be needed in the local communities. We intend to change the definition of the psychiatric technician to include those persons who work in local county hospitals and other local, public and private facilities. These individuals must be trained. Where are they going to get their training? We can't start with brand new facilities in all of the counties who don't have the experience that you have had and which the doctors have had on staffs of our state hospitals. Training for all these local facilities must come from our large training centers which will be the state hospitals. Unfortunately, many of you will be pulled away from the bedside work that you are doing now. Many of you will be called on to train other psychiatric technicians even to a greater extent than you are doing today. This I think may not be realized immediately at the coming session, but it will definitely be part of the trend in the next few years.

Then we have the final prediction which I would like to make before giving you some of the details about this Mental Health Act. My final prediction is (and it's not one based on medical knowledge because I'm not a doctor) but it seems to me fairly obvious from the figures we have been receiving consistently for several years, that the need for hospitals will continue simply because more of our people are cracking under the strain of an advanced technology that we have in our society – they are cracking under the strain of the rat race – the enormous amount of worry we seem to be doing, both public and private, about private affairs and public affairs which are becoming more difficult and complex. We have wars overseas – too many of our young men are being killed – down to city problems even though it may be just wrestling over a city ordinance.

We hear that the need for mental health services is lessening. This is one of the misleading statements that has been made frequently with respect to the cuts in the field of the Mental Hygiene Department and the staff. I challenged the Administration time and time again, publicly, in press conferences, on the air, and elsewhere, to take part in panel discussions with the Director of Mental Hygiene on this one point. I thought it was a cruel and misleading approach to say that because of the population in the state hospitals the population is now lower than it was on any given day last year or two years ago – that there is no longer any need for additional personnel or that the personnel can be reduced in direct proportion to that reduction in population. The actual total number of patients treated in our state hospitals is still growing each year by some 12-13 thousand. In fact, the first six months of this year, the increase was very sharp over last year . . . . . a lot more than were actually predicted . . . . . which means we will actually need more personnel, rather than less, and I hope we discover that officially at the proper level of our state government in time to reverse the present trend of cutting back. People don't realize that even though there may be, and there is, a smaller total number of patients in the hospitals here today, that thousands more are being treated. We have been able to reduce drastically over the

last few years, the total amount of time which an individual patient spends in the hospital. That doesn't mean the service drops. The service to each patient goes up, and it doesn't mean there are less patients, because as the figures have indicated, there are thousands and thousands more patients each year than we have ever had before. When you combine all these things and put them together, I don't see how people can say that they see the hospitals are going to be folded up – either because of the Governor and his cutbacks or because of the Lanterman-Petris-Short bill.

What does the Mental Health Act of 1967 provide that might give us a little hint toward the future? Well, Mr. Lanterman started on this problem in 1955, before I ever went to the Legislature. He and I were both concerned about the commitment process – the thing that happens before you people ever see the patient. We found that we have an ancient commitment procedure in this state which has resulted in some terrible injustices with the result that over the years thousands upon thousands of persons have been transferred to state hospitals who didn't belong there. I'm sure many of you are aware of this. It happened that many persons, particularly an older age group – the senior citizens category who had no relative to look after them or whose relatives and friends turned their backs on them, became the victims of a combination of indifference, apathy, and downright hostility on the part of private citizens and the budget consciousness of public officials. We found that many, many counties who simply did not want to pick up the tab for taking care of some of these senior citizens locally, felt they would take the least expensive way out and simply dump them into the state hospitals because of the fact that the state picked up 100% of the tab and the local county doesn't have to pay anything. We found in the course of our research, that some 3,000 to 3,500 senior citizens were being wrongfully dumped into state hospitals every year. But the county officials seized upon some eccentricity – some little form of senility or something along that line – but certainly not a person who was psychotic under the law and belonged in a state hospital. We also found that there was a sharp decline in their desire to live. This happened many times, 80 percent of these people died the first year after coming into the state hospital under those conditions. We wanted to eliminate that.

Once we got into the possibility of changing the commitment procedure, then of course we became involved in what happened to these people at home, and we had to lay out a program designed to offer the maximum amount of service. That is basically what we do with the Lanterman-Petris-Short bill. We have a pre-petition screening to avoid unnecessary involuntary detention. The whole thrust of the bill really goes to the commitment process. We try to reduce the proportion of those who are committed involuntarily and increase the percentage of those who seek attention voluntarily. This is a program which was tried in other states with this emphasis, and it worked beautifully, and we hope that it will work as well here. Some of our hospitals are doing it already, as a matter of fact. We have a comprehensive evaluation of a patient which is necessary to determine the nature of his problems and the best solutions, locally with the screening committee. We want to tie the involuntary detention and treatment through a certification procedure and not just through a court hearing which takes only a matter of four and one-half minutes in most parts of the state. When people come into court, bewildered after three days of intensive observation, in many cases before they know what has happened, the judge has banged his gavel and said, "This person is going to such and such a hospital," and that's the end of it . . . . .
We allow a maximum of 14 days for involuntary treatment, and no extension of that unless there is another screening process and full and ample opportunity for a hearing before the patient is moved on

to the next step. The right to a court hearing, when it is requested, is made during the first 14 day period. We have additional periods of 90 days of involuntary commitment for the benefit of persons who are proved in court to be dangerous to others. In this area we left out the point of being "dangerous to themselves". This is an area of great controversy, but the experts themselves are divided on the question, and after serious consultation with many experts and consideration of the problem, we decided to omit, not to include, the area "dangerous to themselves" because we were convinced by the majority of the experts that this was really the best thing for the patient and that it would reduce the incidence of suicide. We have two options available to judges. Whether they refer people to state hospitals or a local facility, to an alcoholic clinic, alcoholic treatment facility, and so forth. Now, you see the major emphasis is, number one, away from relying on automatically sending people far away from their homes to a massive institution, and continuing the previously established policy of 1957, of more care at home. Number two, a great deal more concern about what happens to the individual as a person in the commitment process, and after he gets in the hospital. Number three, a much greater variety of choices for courts and local judges as to what can be done, and a much greater regulation about what should be done by direction from the state than we've ever had before. Then, after the patient gets to the hospital, he's going to have many more rights than he had before – the right to wear his own clothing instead of some type hospital garment; the right to keep his own personal possessions, including his toilet articles, and the right to spend a certain amount of his own money for canteen expenses and small personal items; the right to have access to individual storage space, (Some of you who think we are crowded now may laugh at that, but we all know that this has to be worked out.); the right to see visitors each day; the right to have reasonable access to telephones, both to make and receive confidential calls, and we had a lot of static on this too; the right to access to letter writing materials, including envelopes and stamps, and the right to receive and mail unopened correspondence; the right to refuse shock treatment; and the right to refuse a lobotomy. The denial of these rights, if it has to do with treatment and is in the interest of the patient, can be made by the appropriate person on the medical staff. However, an evaluation must be made, and indication must be made in writing in the file as to why the particular right has been taken away both for the purpose of reviewing and for rectifying, if need be, in case the patient wasn't helped and we need to find out why the policy of the bill was not carried out.

There are several other provisions in the bill, and many of them are simply repeating present law, but those are the basic parts. I just thought I would describe them to you, partially to give you a picture of what to expect in the next few years. In closing, once again I want to say that I, as a member of the Legislature, am very grateful to each and every one of you for the services of you personally and as a group, performing the tasks you are doing and have done through the years. Speaking of transferring other people and going other places, if we lost you psychiatric technicians, we might just as well close up these hospitals because we can't do any good without you. There are more of us who know that than you probably know or understand. There are many of us who are concerned about the problem that we haven't been able to move ahead with you as fast as we would like. This new law as it goes into effect in July, 1968, may need changes that we do not know. We would greatly appreciate your help and recommendations before it goes into effect because we have a full and regular session. We deliberately established a lead time of a full year for all persons who are directly concerned to study it thoroughly

and give us recommendations for improvements in the law, refining it so we can improve services and also upgrade training and standards and compensation and everything that goes with the need to have the best possible personnel continue to serve us.

With that I will thank you for extending me the honor of addressing you, and hope you can go back to your respective hospitals refreshed and with new ideas and new determination. I wish each and every one of you the best of success in every area of this field.

I thank you very much.

Question by Executive Director:

It has been suggested in some quarters that the best method of transferring from the state hospital to the community programs would be for us to become something other than psychiatric technicians; to give up the role and become LVN's or something else. Could we have your comment on this, Senator?

SENATOR PETRIS: I personally would be opposed to having your classification changed to one that doesn't mention your training, your experience, or your background. I think as a counter measure it would be wise to have legislation and to have you work hard for it, which creates official recognition – in the form of licensing if that appears necessary and it may well be the best form – of your own classification rather than being classified as LVN's or anything else. I would heartily oppose any effort, and I know some people have interpreted it this way, to state that if you are moved into a county setting you are automatically going to be classified as LVN and that's the end of it. I think you should fight for your own classification which is unique, to get official recognition at the local level as well as the national level. The LVN's, and I have nothing against them and don't mean to be critical of them, are simply not trained and do not have the background to do your work. I would urge you to band together and make that one of your most urgent programs for 1968. I would be in your corner and I will do everything I can to see that your classification is officially recognized that way, and if you need licensing in that category, then let's go after licensing. I wish you the best of luck.

APPENDIX I

ALL THAT GLITTERS MAY NOT BE GOLD

Californians have always taken great pride in "pioneering". The cries of "Eureka" brought strong-hearted individuals from all over the world to California a century ago. Such persons were quick to find out however, that all that glittered on the ground of the Golden State was not gold.

The 1967 Legislature has pioneered in the field of mental health with the adoption of the Lanterman-Petris-Short Act. The motivation behind this Legislation was definitely good. The legislation was directed primarily at the practice of indefinite court commitments to State Hospitals which definitely had been abused in some counties. The Act, however, goes far beyond these problems and will revolutionize the treatment of the mentally ill in this State. Unfortunately the philosophy contained in the Bill that only those individuals who have threatened or attempted injury on the person of another need more than 14 days involuntary treatment is not a medically accepted fact. Unless amended by the State Legislature, this "noble experiment" will be put into effect during the current year. Regardless of the outcome, it will have a dramatic effect upon all non-governmental psychiatric hospitals.

The question still remains whether either the mentally ill and the profession of psychiatry can live with the Act. What is even more important, is whether or not society can live with it.

Robert Thorn, President
Vista Hills Psychiatric Foundation

5 January 68

APPENDIX II

I

Curriculum Report ..... by Anabele Miller

The area of psychiatric technician training is one that has received considerable attention in the last ten years. Providing adequate care for patients in psychiatric hospitals, schools for the mentally retarded and other mental health facilities is a problem that has been brought sharply into focus by the 1962 Report of the Joint Commission on Mental Illness and Health.

Statistics indicate that most of the 24-hour-a-day care of patients in psychiatric hospitals is given by a group of workers variously designated as psychiatric technicians, aides, attendants and nursing assistants. Up to the present time, they have constituted approximately 80 percent of the nursing personnel in psychiatric institutions. Of all the people concerned with the treatment and care of the psychiatric patient, the psychiatric technician has the most continuous and constant interaction with him. The technician has the opportunity to develop close relationships with patients and for observing their behavior in a variety of situations.

The question has been raised as to the most effective and efficient way to train this category of worker so that he can make the most useful contribution to the care of patients and families in community mental health facilities.

With this in mind a committee has been working during the past several months to develop an effective training program for psychiatric technicians. The committee has suggested the following framework for the development of such a program.

The purpose of the program is to train a generalized psychiatric technician practitioner who can function therapeutically with patients and families in the hospital, the home and the community.

The primary difficulty with college-based programs is their lack of relevance to problems confronted on the job. The difficulty with in-service training is the low level of cognitive areas of learning that give a broader base of understanding to the mental health worker.

This training program is also an open-ended course of study and practice that will permit the psychiatric technician to augment his academic achievement, if able and motivated, with a further career in the mental health field.

OUTLINE OF RECOMMENDED PSYCHIATRIC TECHNICIAN STUDY PROGRAM

First Semester	Semester Credits
Clinical Work Experience	4
and Seminar	3
Group & interpersonal Process Lab	2
Psychology	3
Sociology	3
Physical Education	½
	15½

Second Semester	
Clinical Work Experience	4
and Seminar	3
Group & INterpersonal Process Lab	2
Growth & Development	3
Health & Education	2
Elective	2-3
Physical Education	½
	16½—17½

Third Semester	
Clinical Work Experience	2-4
and Seminar	2
Group Process Lab	2
Abnormal Psychology	3
Elective	3
English Composition	3
Physical Education	½
	15½—17½

Fourth Semester	
Clinical Work Experience	2-4
and Seminar	2
Group Process Lab	2
Elective	4-6
American Hist. & Govt.	3
Physical Education	½
	13½—17½

ASSOCIATE IN ARTS DEGREE ELECTIVES

Anatomy & Physiology
Pharmacology
Anthropology
Learning Theory
Sociology of Mental Health
Social Psychology — Art
Aging — Music
Community Organization & Social Case Work
Special Studies — Honors
Sociology of the Family
Introduction to Data Processing

THE NATIONAL ASSOCIATION OF PSYCHIATRIC TECHNOLOGY

and

THE CALIFORNIA SOCIETY OF PSYCHIATRIC TECHNICIANS

are dedicated to the demonstrated competence of psychiatric technicians in the areas of behavioral care, treatment and training. We feel that curriculum and standards must be developed for the entire profession, adaptations must be periodically reviewed and modified to the changing focus of the mental hygiene field, and through these changed accents, the skills, treatment and training of the psychiatric technician must be enhanced and the technician himself challenged.

We need your assistance. In order to press for increased recognition, to work for professional development and recognition, improved working conditions and higher salaries, to establish high standards of our profession through legislative action and to develop a uniform curriculum nation-wide, we must have financing.

The status of the psychiatric technician has consistently been improving, and it can be greatly accelerated through your cooperation and support.

Please send me a membership application in THE NATIONAL ASSOCIATION OF PSYCHIATRIC TECHNOLOGY, 1127 – 11th Street, Sacramento, California 95814.

Name _____
Last 1st Initial 2nd Initial

Address _____ Phone _____

City _____ State _____ Zip _____

Please direct me to the state psychiatric technicians association in my state. ☐

I would like information on helping to form a state psychiatric technicians association ☐